

## APPLICATION FOR LIVING BENEFITS

Please complete this form in its entirety to present your claim for the Living Benefit under your Wisconsin Public Employers' Group Life Insurance Plan. All questions must be completed fully. The claimant or the claimant's legal guardian for the estate must sign and date the authorization.

### 1. EMPLOYEE INFORMATION.

Employee Name (Last, First, Middle Initial)	Social Security Number	Birthdate (MM/DD/CCYY)
Address (Street, City, State, Zip)		Daytime Telephone Number

### 2. APPLICANT INFORMATION. (Complete only if the claimant is the spouse or dependent child of the employee.)

Relationship to Employee: <input type="checkbox"/> Spouse (Date of Marriage _____) <input type="checkbox"/> Dependent Child		
Legal Name of Applicant (Last, First, Middle Initial)	Social Security Number	Birthdate (MM/DD/CCYY)
Address (Street, City, State, Zip)		Daytime Telephone Number

3. Are you, the claimant, required by law to apply for this benefit in order to meet the claims of creditors or in order to obtain a government entitlement? ☐ Yes ☐ No (If Yes, you are not eligible for this benefit.)

4. Living Benefit Option under which you are applying (check appropriate box):

☐ Terminal Condition Option ☐ Confinement Option ☐ Hospice Care Option

5. What amount are you requesting as a Living Benefit? Your request must be in whole thousands of dollars. You must request at least \$5,000 (or the entire value of your coverage, if less).

\$ \_\_\_\_\_ - or - ☐ Entire value of my coverage

6. Please describe fully the nature of the disease or injury for which you are claiming benefits.

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7. Date you were first treated for your present condition (MM/DD/CCYY) \_\_\_\_\_

8. Do you presently require confinement or hospice care?

☐ Yes – Please answer questions 9-14. ☐ No – Skip to question 13.

9. Name of confinement facility or hospice care provider \_\_\_\_\_

10. Address (Street, City, State, Zip) \_\_\_\_\_

11. Date Admitted \_\_\_\_\_ (MM/DD/CCYY)

12. Date Discharged \_\_\_\_\_ (MM/DD/CCYY) (if applicable)

13. Name and address of physician(s) who treated you for your current condition.

PHYSICIANS NAME AND ADDRESS	DATE FROM	DATE TO

14. Name and address of physician(s) who treated you within the last five years for any cause. If none, check box. ☐

PHYSICIANS NAME AND ADDRESS	DATES	CAUSE

I hereby voluntarily apply for a Living Benefit in the amount stated on the reverse side. I understand that my life insurance coverage under the Wisconsin Public Employers' Group Life Insurance Program will be reduced by the amount of any Living Benefit paid to me. If I receive the entire benefit, my coverage will cease and no further benefit will be payable.

**AUTHORIZATION FOR RELEASE OF MEDICAL AND EMPLOYMENT INFORMATION:** I authorize any provider of health care, physician, medical practitioner, psychologist, chiropractor, hospital, including Veterans Administration Hospital, clinic or other health care facility, insurance company, consumer reporting agency, Social Security Administration, Internal Revenue Service, financial institution, employer, rehabilitation facility, or other organization or person which has any records or knowledge of my physical or mental health or financial information or employment, to give all such information it has to **The Minnesota Life Insurance Company** (Company) or its authorized representative. This shall include but not be limited to information regarding any medical or health history including all consultations, diagnoses, prescriptions, treatments, tests, as well as any information regarding alcohol or drug abuse, AIDS or AIDS-related conditions.

I understand that this information is to be used to determine my eligibility for insurance benefits under my claim and I authorize the Company to release any such information for that purpose to the following persons or organizations: reinsuring companies, persons or organizations performing business, legal, or medical services related to the claim; or to any other public or private entity as may be lawfully required.

This authorization shall be valid as long as I am making a claim against the Company. I have read and understand this authorization. I know that I may request and receive a copy of it. A photocopy of this authorization is as valid as the original.

I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, all information in this application is true and correct.	
Date (MM/DD/CCYY)	Signature of Applicant or Applicant's Legal Guardian

**Return this *Application for Living Benefits* to Minnesota Life Insurance Company, P.O. Box 259708, Madison, WI 53725-9708.**  
**You will then receive a form to be completed by your attending physician and by the provider of confinement or hospice care if applicable.**